STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155605	A. BUILDING _____ B. WING _____	C 03/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH & REHABILITATION CENTER	1959 E COLUMBUS ST MARTINSVILLE, IN 46151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of complaint number IN00086438 and complaint number IN00087218. Complaint number IN00086438, Unsubstantiated-due to lack of evidence. Complaint number IN00087218, Substantiated, no deficiencies related to the allegations are cited. Survey dates: March 7 and 8, 2011 Facility number: 000400 Provider number: 155605 AIM number: 100266880 Survey team: Carol Diane Dierks, RN, TC Marcy Smith, RN (March 7, 2011) Rhonda Stout, RN (March 7, 2011) Leia Alley, RN (March 7, 2011) Census bed type: SNF/NF: 52 SNF: 8 Total: 60 Census payor type: Medicare: 12 Medicaid: 42 Other: 6 Total: 60 Sample: 10 Grandview Health & Rehabilitation Center was found to be in compliance with 42 CFR Part 483	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155605	A. BUILDING _____ B. WING _____	C 03/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH & REHABILITATION CENTER	**1959 E COLUMBUS ST MARTINSVILLE, IN 46151**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 Subpart B and 410 IAC 16.2 in regard to the Investigation of complaint number IN00086438 and complaint number IN00087218. Quality review completed 3-10-11 Cathy Emswiller RN	F 000		